Direct Access Endoscopy Procedure Request Form

Please complete all known information on this form and email to SAIBT@ccf.org

For referral appointments by telephone please call our dedicated Referrals Line on 07922 101780

Patient Details	**Referrer Details**
Title:	Name:
Surname:	Practice name:
First name:	Street address:
Sex:	Postcode:
Date of birth (DD/MM/YYYY):	Telephone No.:
NHS No. (If known):	Email:
Street address: Postcode:	**Payment Details**
Telephone / Mobile:	Please note Direct Access Endoscopy is Self pay only
Email:	

Clinical Information			
Test Required	Gastroscopy (OGD) ☐	Colonoscopy ☐	Ogd & Colonoscopy ☐
Indication for test and reason for referral:			

Drug & Medical History					
	Yes	No		Yes	No
Anticoagulant / Antiplatelet Therapy	Yes	No	Rheumatoid Arthritis	Yes	No
Aspirin	Yes	No	Cardiovascular (specify in Other)	Yes	No
Diabetes - Insulin or Tablet	Yes	No	Pacemaker	Yes	No
Infection Risk (HIV / TB / Hepatitis / CJD)	Yes	No	Respiratory (specify in Other)	Yes	No
Other (Please specify:					
Does the patient have any allergies? *If yes, please describe*	Yes	No			
Are there any accessibility / mobility concerns? *If yes, please describe*	Yes	No			

By completing this section, you confirm you have completed a clinical assessment

I authorise this patient to undergo the above procedure

Signature: ______________________ Date: ______________________